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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0040	A. BUILDING _____ B. WING _____	03/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLS PLACE	404 NEWCOMB ST, SE WASHINGTON, DC 20032

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I 000	INITIAL COMMENTS A licensure survey was conducted on March 8, 2011, to March 11, 2011. A random sample of three residents was selected from a resident population of four men and one woman. The survey findings was based on observations in the home, interviews with administrative, nursing and direct care staff and residents as well as a review of resident and administrative records, including incident reports.	I 000	Received 4/12/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the resident's modified diet was reviewed at least quarterly by the consulting dietitian for one of the three residents included in the sample. (Resident #1) The finding includes: Interview with the direct care staff on March 10, 2011, at approximately 4:08 p.m., revealed that all the residents were on a 1800 calorie diet with the exception of Resident #1. According to the direct care staff, Resident #1 was on a 2200 calorie diet. Review of Resident #1's medical record on March 9, 2010, at approximately 11:30 a.m., revealed he was seen by his Primary Care Physician, (PCP) on September 13, 2010 and was	I 043	Diets on all Residents will be reviewed by a licensed dietitian of a quarterly basis as per regulation. Carl's Place will work with DDS Services Coordinators to ensure that the PSI contracted dietician reviews and assess the dietary regimen of each resident in accordance with PCP orders and the residents ISP. 4/30/11 All dietary care coordination will be properly documented in the Residents medical record.	

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Karen Hutchinson — TITLE CEO — (X6) DATE 4-11-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 043	Continued From page 1 prescribed a 2200 calorie diet. Continued review of the medical record revealed a nutrition quarterly review dated July 26, 2010. At the time of the survey, the GHPID failed to show evidence that a dietitian had reviewed Resident #1's modified diet since the assessment conducted July 26, 2010.	I 043		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review the GHPID failed to ensure unusual incidents that interfered substantially with the resident's health was reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for one of the three residents included in the sample. (Resident #1) The finding includes: A review of the facility's incident reports on March 8, 2011, beginning at approximately 10:17 a.m. revealed Resident #1 experienced a seizure while	I 379	Carl's Place implemented a new incident reporting system where by all incidents are reported to t the Program Director immediately. All serious reportable incidents will be submitted to DDS MCIS system and the DC Department of Health within 24 hours. All incidents will be logged in the incident report log book where they be reviewed by the QA Coordinator to monitor for compliance.	4/30/11

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I 379	Continued From page 2 he was on an outing on September 9, 2010. According to the report, the direct care staff called 911 and the resident was transported via ambulance to a local emergency room. Although the Program Director stated on March 8, 2011, at approximately 10:56 a.m. that the incident was reported to DOH/HRLA, there was no evidence of the incident being reported.	I 379		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure the provision of nursing services in accordance with the assessed needs of five of the five residents residing in the GHPID (Residents #1, #2, #3, #4, and #5). The findings include: 1. The GHPID failed to ensure that medications for Residents #1 and #2 were administered in	I 395	As of March 21, 2011, Carl's Place has contracted with the Mid-Atlantic Coordinating Center/[redacted] RN/CMDN and [redacted] RN/CMDN to provider RN oversight related to nursing services and the delivery of nursing care. The following actions are being instituted to begin to correct the deficiencies identified in ID Prefix Tag 1395 • MAR's for all residents are in the process of being audited, according to the nursing process which includes checking both the MAR and the physician order for completeness and accuracy. • A meeting has been scheduled between the oversight RN's and the residents' PCP and Psychiatric provider to ensure that all medication/treatment orders are current and properly authenticated by each practitioner.	

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I 395	Continued From page 3 compliance with physician's orders. a. . Review of the incident reports on March 8, 2011, beginning at approximately 10:17 a.m., revealed Resident #1 was involved in an incident dated September 9, 2010. According to the report, the resident experienced a seizure while he was on an outing. The resident was seen in a local emergency room, and subsequently on September 15, 2010 the resident visited his neurologist and his Trileptal was increased from 300 mg BID to 300 mg Q A.M. and 600 mg. Q P.M. to control his seizures. Although the neurologist increased the dosage, the resident's Medication Administration Records (MAR) for September 2010, October 2010, November 2010, and December 2010 remained the same (Trileptal 300 BID). There was no documented evidence that the resident received the additional 300 mg in the PM as prescribed. Although the January 2011 MAR, reflected the prescribed dosage (Trileptal 300 mg QAM and 600 mg QPM), the MAR was altered (line drawn through dosage and frequency) to reveale the previous dosage of (300 mg BID). The MARs from September 2010 through January 2011 indicated that the resident did not receive the increase in Trileptal as ordered by the neurologist. The MAR's from September 2010 through January 2011 indicated that the resident did not receive the increase of Trileptal as ordered by the neurologist. On the morning of March 10, 2011 at approximately 8:46 a.m., an interview was conducted with the LPN, who signed the MAR's.	I 395	• The current LPN has been replaced. A revised LPN position description, emphasizing care coordination and team management is now in place and a new LPN has been hired, orientation given, as will start his duties the week of 4/18/11. • A med-pass observation is being schedule for the newly hired LPN to ensure that he is knowledgeable and competent with regards to medication administration.	

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I 395	Continued From page 4 According to the LPN, he had no knowledge of the neurological appointment that Resident #1 had on September 15, 2010, and indicated that he was not aware of the increase of the Trileptal. The LPN also revealed that there was no system in place for him to know that the resident had been seen by the neurologist. When informed of the medication error, he indicated that it was not his responsibility to verify the order as he was only doing the medication pass. He also indicated that the agency had been without a registered nurse for appropriately 9 months. When furthered questioned about his nursing duties, he added that he communicates with the residents' Primary Care Physicians (PCP), and writes nursing notes and orders. Interview with the Administrator and Program Director on the same day, revealed the LPN had a mailbox in which the medical consults are placed for his review. Further interview revealed that it was the LPN's responsibility for any new orders to be faxed to the pharmacy. Review of the nursing job description confirmed his duties as stated above and included the following: Administer medications and treatments per physician's orders; Transcribe physician's orders received on tour of duty; Review MAR/narcotic count sheet for completeness before end of duty; Schedule and follow-up medical appointments; and Communicate any changes in resident's condition to the RN. Review of the February and March 2011 MARs however, reflected the neurologist ' s September 15, 2010 order (Trileptal 300 mg QAM and 600	I 395		

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I 395	Continued From page 5	I 395		

mg QPM). Observation of the evening administration medication pass on March 10, 2011, at approximately 4:27 p.m. confirmed that Resident #1 was administered Trileptal 600 mg.

b. Observation of the evening medication pass on March 10, 2011, at approximately 4:42 p.m. revealed Resident #2 was administered Seroquel 50 mg, Lamotrigine 150 mg and Keppra 750 mg.

Review of the resident's clinical records revealed a physician's order, dated September 21, 2010 for Depakote 500 mg two (2) tablets once daily. Review of the September 2010 MAR's reflect that the LPN drew a line through the "once" daily and wrote "BID." The MAR's for September, October, November, and December 2010 revealed that Resident #2 was administered Depakote 1000 mg twice a day. There was no evidence that the physician had increased the Depakote to BID. Also, there was no evidence that the physician was notified of the September through December medication errors.

c. Observation of the evening administration medication pass on March 10, 2011, at approximately 4:42 p.m. revealed Resident #2 was administered Seroquel 50 mg (1 tablet). Review of the resident's medical record on March 10, 2011 at approximately 1:59 p.m., revealed a physician's prescription, dated September 21, 2010, that prescribed Seroquel 50 mg, one tablet twice daily. Review of the March 2011 MAR, revealed that the client was administered 100 mg of Seroquel in the morning and 50 mg in the evening. Further review of the resident's medical records revealed a pharmacy pre-printed physician's order, dated March 1, 2011 that reflected Seroquel 50 mg to be given twice in the morning and once in the evening. The

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I 395	Continued From page 6 pre-printed order was not signed by the resident's physician or by a registered nurse. The most current signed physician ' s order was dated September 21, 2010. 2. The GHPID staff failed to provide Nursing oversight for all the residents who reside in the facility. (Residents #1, #2, #3, #4, and #5) Interview with the GHPID's LPN on March 10, 2011 beginning at 8:46 a.m., revealed the facility had been without a Registered Nurse (RN) for approximately nine (9) months. During the entrance conference interview with the Program Director on March 8, 2011 at approximately 10:08 a.m., revealed all the residents residing in the facility were prescribed Psychotropic medication. Residents #1, #2, #3, #4, and #5) [See #1, a - c]	I 395		
I 412	3520.13 PROFESSION SERVICES: GENERAL PROVISIONS If a resident evidences the need for a professional service for which arrangements do not exist, the GHMRP shall have fourteen (14) days to show evidence of arrangements for provision of the professional service, except that in life threatening situations, arrangements must be made immediately. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the provision of a Behavior Support Plan (BSP), for one of the three residents included in the sample. (Resident #2)	I 412		

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I 412	Continued From page 7 The finding includes: Interview with the Program Director on March 11, 2011, at approximately 2:48 p.m., revealed that Resident #2 was prescribed psychotropic medications, but he did not have a Behavioral Support Plan. The interview also revealed the resident received Medicaid Waiver Services. A review of the resident's medicaid waiver authorization revealed he had been approved to receive a BSP initial assessment as of April 27, 2010. At the time of the survey, the GHPID failed to arrange for Resident #2 to receive his initial assessment for a BSP before administering psychotropic medications.	I 412	Carl's Place will be contracting with a Licensed Behavior Specialist to develop the Diagnostic Assessment and Behavior Support Plan for Resident #2.	4/30/2011
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview and record verification, the Group Home for the Persons with Intellectual Disabilities (GHPID) failed to report irregularities in the drug regimens to the Primary Care Physician (PCP) for two of the three residents included in the sample. (Residents #1 and #2) The finding includes: The facility failed to report irregularities in the drug regimens to the Primary Care Physician (PCP) for Residents #1 and #2. [See medication errors as reflected in 3520.2 (e)]	I 473	1473 The nursing oversight RN's are in the process of developing a systematic protocol which will document and identify suspected or confirmed drug irregularities. Such system will include: ✓ Incident Reporting ✓ Immediate RN/Managerial notification ✓ Alert individual's physician for remedial action and f/u recommendation(s).	4/30/11

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I 500	Continued From page 8	I 500	1473 • A newly established consultation protocol has been developed which will allow for the oversight RN's to: ✓ review and sign-off on all consults ✓ take-off and fax to the Pharmacy all recommended orders ✓ Ensure that all recommended order are also reviewed and approved by the PCP ✓ Ensure timely scheduling of all recommended return/follow-up visits	4/30/11
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District laws that govern the care and rights of persons with mental retardation, for two residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: 1. (Chapter 13, § 7-1305.05.(h) all customers shall have the right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written or verbal order of a licensed physician, noted promptly in the patient's medical record and signed by the physician within 24 hours. The GHMRP failed to demonstrate protection of Resident #1's right to be free from unnecessary or excessive medication; specifically, psychotropic medications as evidenced below: During the entrance conference on March 8, 2011 at approximately 10:08 a.m., interview with the Program Director revealed Resident #1 had a legal guardian. Continued interview with the	I 500	1473 • Direct care staff are currently in the process of being in-serviced on each Residents HMCP, BSP (if applicable) ISP goals and objectives. In addition there will be scheduled In-services on individual diet plans and major medical diagnosis. • All nursing polices and procedure/protocols (including Incident reporting) are currently being revised by the oversight RN's –to reflect best practices and regulatory mandates All new policies will be reviewed by management and all persons involved in care coordination will receive an orientation to all new policies.	4/30/11

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I 500	Continued From page 9 Program Director revealed the resident had been prescribed psychotropic medication. Review of the residents' record on March 10, 2011 at approximately 11:02 a.m. revealed a psychotropic medication review dated October 10, 2010. Further review of the medication review revealed the psychiatrist recommended Resident #1's Seroquel XR to be increased from 200 mg to 400 mg. Although the resident had consent for the Seroquel XR 200 mg, there was no documented evidence of consent for the Seroquel XR 400 mg. At the time of the survey, the GHMRP failed to protect Resident #1's right to be free from unnecessary or excessive medication; specifically, to ensure informed consent was provided before the administration of the increase of his psychotropic medication. 2. The GHPID failed to ensure that medications for Residents #1 and #2 were administered in compliance with physician's orders. a. Review of the incident reports on March 8, 2011, beginning at approximately 10:17 a.m. revealed Resident #1 was involved in an incident dated September 9, 2010. According to the report, the resident experienced a seizure while he was on an outing. The resident was seen in a local emergency room, and subsequently on September 15, 2010 the resident visited his neurologist and his Trileptal was increased from 300 mg BID to 300 mg Q A.M. and 600 mg, Q P.M. to control his seizures. Although the neurologist increased the dosage, the resident's Medication Administration Records (MAR) for September 2010, October 2010, November 2010, and December 2010 remained the same	I 500	1473 • Oversight RN's/management will be responsible for reviewing resident's BSP's and ISP's for completeness /accuracy and to ensure that all residents who are on Psychotropic meds have current BSP's. 1500 Residential Director will obtain consent forms from guardians when there are changing in psychotropic medications. All psychotropic medications will be reviewed by HRC. Consent forms will be entered into medical records and be available for inspection. Consent form for Resident #1 has been signed and entered into medical record.	

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I 500	Continued From page 10 (Trileptal 300 BID). There was no documented evidence that the resident received the additional 300 mg in the PM as prescribed. Review of the January 2011 MAR reflected Trileptal 300 mgs every morning and 600 mg at bedtime. Further review of the January MAR, however, revealed a line drawn through "every morning" and a line drawn through "at bedtime." Written over those words was "BID." Also lined through was the 600 mg (at bedtime dosage) and written on top was 300 mg. The MARs from September 2010 through January 2011 indicated that resident did not receive the increase in Trileptal as ordered by the neurologist. On the morning of March 10, 2011 at approximately 8:46 a.m., an interview was conducted with the LPN, who signed the MARs. According to the LPN, he had no knowledge of the neurological appointment that Resident #1 had on September 15, 2010, and indicated that he was not aware of the increase of the Trileptal. The LPN also revealed that there was no system in place for him to know that the resident had been seen by the neurologist. When informed of the medication error, he indicated that it was not his responsibility to verify the order as he was only doing medication pass. He also indicated that the agency had been without a registered nurse for appropriately 9 months. When furthered questioned about his nursing duties, he added that he communicates with the residents' primary care physicians, and writes nursing notes and orders. Interview with the Administrator and Program Director on the same day, revealed the LPN had	I 500	As of March 21, 2011, Carl's Place has contracted with the Mid-Atlantic Coordinating Center/[redacted] RN/CMDN and [redacted] RN/CMDN to provider RN oversight related to nursing services and the delivery of nursing care. The following actions are being instituted to begin to correct the deficiencies identified in ID Prefix Tag 1395 • MAR's for all residents are in the process of being audited, according to the nursing process which includes checking both the MAR and the physician order for completeness and accuracy. • A meeting has been scheduled between the oversight RN's and the residents' PCP and Psychiatric provider to ensure that all medication/treatment orders are current and properly authenticated by each practitioner.	4/30/2011

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I 500	Continued From page 11 a mailbox in which the medical consults are placed for his review. Further interview revealed that it was the LPN's responsibility for any new orders to be faxed to the pharmacy. Review of the nursing job description confirmed his duties as stated above and included the following: Administer medications and treatments per physician's orders; Transcribe physician's orders received on tour of duty; Review MAR/narcotic count sheet for completeness before end of duty; Schedule and follow-up medical appointments; and Communicate any changes in resident's condition to the RN. Review of the February and March 2011 MAR reflected the neurologist ' s September 15, 2010 order (Trileptal 300 mg QAM and 600 mg QPM). Observation of the evening administration medication pass on March 10, 2011, at approximately 4:27 p.m. confirmed that Resident #1 was administered Trileptal 600 mg. b. Observation of the evening medication pass on March 10, 2011, at approximately 4:42 p.m. revealed Resident #2 was administered Seroquel 50 mg, Lamotrigine 150 mg and Keppra 750 mg. Review of the resident's clinical records reviewed a physician ' s ordered, dated September 21, 2010 for Depakote 500 mg two (2) tablets once daily. Review of the September 2010 MARs reflect that the LPN drew a line through the "once" daily and wrote "BID". The MARs for September, October and December 2010 . revealed that Resident #2 was administered Depakote 1000 mg twice a day. There was no	I 500	• The current LPN has been replaced. A revised LPN position description, emphasizing care coordination and team management is now in place and a new LPN has been hired, orientation given, as will start his duties the week of 4/18/11. • A med-pass observation is being schedule for the newly hired LPN to ensure that he is knowledgeable and competent with regards to medication administration.	4/30/11

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0040	A. BUILDING _____ B. WING _____	03/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 500	Continued From page 12 evidence that the physician had increased the Depakote to BID. Also, there was no evidence that the physician was notified of the September through December medication errors. c. Observation of the evening administration medication pass on March 10, 2011, at approximately 4:42 p.m. revealed Resident #2 was administered Seroquel 50 mg (1 tablet). Review of the resident's medical record on March 10, 2011 at approximately 1:59 PM, revealed a physician's prescription, dated September 21, 2010, that prescribed Seroquel 50 mg, one tablet twice daily. Review of the March 2011 MAR revealed that the client was administered 100 mg of Seroquel in the morning and 50 mg in the evening. Further review of the resident's medical records revealed a pharmacy pre-printed physician's order, dated March 1, 2011 that reflected Seroquel 50 mgs to be given twice in the morning and once in the evening. The pre-printed order was not signed by the resident's physician or by a registered nurse. The most current signed physician's order was dated September 21, 2010. 2. The GHPID staff failed to provide Nursing oversight for all the residents who reside in the facility. (Residents #1, #2, #3, #4, and #5) Interview with the GHPID's LPN on March 10, 2011 beginning at 8:46 a.m. revealed the facility had been without a Registered Nurse (RN) for approximately nine (9) months. During the entrance conference interview with the Program Director on March 8, 2011 at approximately 10:08 a.m. revealed all the residents residing in the facility were prescribed	I 500		

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I 500	Continued From page 13 Psychotropic medication. Residents #1, #2, #3, #4, and #5) [See #1, a - c]	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted on March 8, 2011, through March 11, 2011. A random sample of three residents was selected from a resident population of four men and one woman. The survey findings was based on observations in the home, interviews with administrative, nursing and direct care staff and residents as well as a review of resident and administrative records, including incident reports.	R 000	Carl's Place will institute the following policy to assure that Criminal Background Checks are completed on all employees: In the interview process the Program Director will ensure that all potential employee for Carl's Place have received a background check from both Metropolitan Police Department and U.S. Department of Justice before employment. The Administrative Secretary will insure that each prospective employees record includes a background check before being interviewed for employment at Carl's Place Inc. The Quality Assurance Coordinator will review all personnel records	4/30/11
R 124	4701.4 BACKGROUND CHECK REQUIREMENT The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. This Statute is not met as evidenced by: Based on interview and review of the records the GHMRP failed to ensure all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. The finding includes: 1. Review of personnel records on March 11, 2011, beginning at approximately 10:42 a.m., revealed that Staff #2 began employment on November 10, 2010. At the time of the survey, there was no evidence that a background check had been obtained for this staff member. 2. Review of personnel records on March 11, 2011, beginning at 10:42 a.m., revealed that Staff #4 began employment on January 8, 2011. At the time of the survey, there was no evidence that a background check had been obtained for	R 124		

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R 124	Continued From page 1 this staff member.	R 124	every (6) six months to assure that all required certifications and documentations are current. These records will become part of the personnel folder and kept on file at the Cooperate office. Prospective employees will not be considered for employment if background checks are not included in the pre-employment personnel records or returned with undesirable results . All employee personnel records now employed at Carl's Place have been researched and any found without U.S. Department of Justice background checks were submitted to CJIS in Clarksburg W.V. for completion of criminal background check on 4-07-11. Records now include documented proof that this process has started. The estimated turn around time for the completion and return of the submitted background checks is (10) ten to (21) days.	4/30/11
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the agency failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for one out of the thirteen staff employed. (Staff #6,) The findings include: Review of personnel records on March 11, 2011, beginning at 10:42 a.m., revealed that Staff #6 began employment on September 8, 2010. Further review of the record revealed Staff #6 was employed in Silver Spring, Md, from September 2004, through December 2005. At the time of the survey, a background check had not been obtained for this employee (7) years prior for all jurisdictions within which the employee worked or resided .	R 125		